DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391	
· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED	
		345329	B. WING		C 06/09/2016	
NAME OF P	ROVIDER OR SUPPLIER		·			
				2030 HARPER AVENUE NW		
GATEWAY	REHABILITATION AND	HEALTHCARE		LENOIR, NC 28645		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		
F 490 SS=C	A facility must be adm enables it to use its re efficiently to attain or practicable physical, i well-being of each res This REQUIREMENT by: Based on observatio interviews, the facility Administrator respons of the last 121 days s survey. The findings included On 06/09/16 at 5:26 F interim Administrator been the Administrator been the Administrator been the Administrator been the Administrator been the Administrator o4/06/16. On 04/04/7 #2) was assigned to t evidence that Adm #2 administrator's license 04/04/16 through 05/7 license expired and w corporation assigned of assistant administr Regional Vice Preside Administrator but was 05/25/16. Adm #1 st administrator for a sis could not be administ	 mental, and psychosocial sident. is not met as evidenced ns, record review and staff failed to have an sible for the facility for 11 out ince the last recertification PM an interview with the (Adm #1) revealed she had or from 01/29/16 until 16 a new Administrator (Adm he facility. Adm #1 provided 2 had a temporary e which was valid from 13/16. Once the temporary vas not renewed, the Adm #2 the responsibilities ator. Per Adm #1, the ent tried to find an interim s unsuccessful until tated she was the ster facility and knew she rator over two facilities at a was in contact as a 	F 49	 Preparation and/or execution of this pl of correction does not constitute admission or agreement by the provide with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by stat and federal law. F490- Administration A North Carolina licensed Administra was hired 05-25-16 and is responsible the overall administration of the facility. The facility will maintain a North Carolin Licensed Administrator in place to administer the facility in a manner that enables it to use its resources effective and efficiently to attain and maintain th highest practicable physical, mental, an psycho-social well-being of each reside Notification of this change was sent to DHHS. No residents were affected by this practice. The facility will continue to 	er ator for na ly e nd ent.	
	Director of Nursing (Director of Nursing (Director of the father overseer over over the father over the fat	stant administrator and the OON), who was appointed cility, until she was able to SUPPLIER REPRESENTATIVE'S SIGNATURE		for the facility.	(X6) DATE	
	DIVED ON DOWNDER/S	JOI T LIEIT NEI NEUENIAIIVEUUGINAIURE		IIILE		

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

06/22/2016

PRINTED: 06/24/2016

DEPARTMENT OF HEALTH				PRINTED: 06/24/201 FORM APPROVEI OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	345329	B. WING		C 06/09/2016
NAME OF PROVIDER OR SUPPLIER	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE	
GATEWAY REHABILITATION AN			2030 HARPER AVENUE NW	
			LENOIR, NC 28645	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
provided document interim Administrate through the presen her license was poor Interview with the D revealed he was no but did oversee the conjunction with Ad returned as official 05/25/16. He state usual with the regu #1 was consulted of normally consult wit the Regional Vice F during that 7 day p consultant was ava	istrator of this facility. She tation that she became the or of the facility on 05/25/16 t day. Observations revealed sted in the facility. DON on 06/09/16 at 5:46 PM ot licensed as an administrator e operations of the facility in dm #1's consultation until she administrator of the facility on ed that the facility operated per lar morning meetings and Adm on any issue that he would th an administrator. In addition President came to the facility eriod and the corporate nurse illable per usual. DON stated d no differently than when the	F 4	 90 3. On 06/23/2016, the North Carc Licensed Administrator was re-ect by the Regional Vice President of Operations (RVPO) on long-term Administrator licensure requirement ensuring the facility is administered manner that enables it to use its resources effectively and efficient attain and maintain the highest pr physical, mental, and psycho-soc well-being of each resident. Newly hired Administrators will be educated by the RVPO upon hire active, good-standing licensure verthe state of North Carolina. 4. The RVPO or licensed regional member designee will monitor face ensure Administrator continues to active license in good -standing a he/she administers facility in a mat that enables it to use its resource effectively and efficiently to attain maintain the highest practicable p mental, and psycho-social well-be each resident. The RVPO or licensed regional te member designee will report findi monthly to the Quality Assurance Performance Committee (QAPI) committee for 6 months or until substantial compliance is obtaine QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance 	ducated f care ent and ed in a tly to racticable dand erified in l team cility to b have an and anner s and bhysical, eing of eam ings

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UJY511

Facility ID: 923160

If continuation sheet Page 2 of 3

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 06/24/2016 APPROVED). 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345329	B. WING				09/2016	
NAME OF PROVIDER OR SUPPLIER GATEWAY REHABILITATION AND HEALTHCARE				20	TREET ADDRESS, CITY, STATE, ZIP CODE D30 HARPER AVENUE NW ENOIR, NC 28645			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 490	Continued From page	2	F	490	make changes to the corrective action necessary.	as		
	7(02-99) Previous Versions Obs	olete Event ID: UJ			sility ID: 923160 If cor		eet Page 3 of 2	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 923160

If continuation sheet Page 3 of 3